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Honorable Salvador Mendoza, Jr.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

CYNTHIA HARVEY, individually and on behalf of all others similarly situated,

Plaintiff,

v.

COORDINATED CARE CORPORATION and CENTENE MANAGEMENT COMPANY, LLC,

Defendants.

No. 2:18-CV-00012-SMJ

DEFENDANTS' OPPOSITION TO PLAINTIFF'S MOTION FOR CLASS CERTIFICATION

Oral argument:

April 14, 2020 at 9:00 a.m. in Spokane

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PRELIMINARY STATEMENT

Coordinated Care's members see out-of-network doctors for a variety of reasons. When a member contacts Coordinated Care or the Office of the Insurance Commissioner to request reimbursement for out-of-network costs, Coordinated Care's member-service team analyzes the request. This happens on a regular basis. For each request, they look into the reason that care was sought from an out-of-network provider, the availability of an in-network provider, the amount of any applicable deductible, and more. This work is necessary to resolve each individual request because in some circumstances, the member is entitled to reimbursement; in others, the member is not—pursuant to the terms of the insurance policy, which describes how out-of-network costs are handled. Requests often involve sensitive medical issues, and significant work goes into resolving each one.

Plaintiffs ask this Court to take on this complex task on a class-wide basis. The Court should decline for two reasons:

First, there are existing ***superior methods*** for addressing costs that Coordinated Care's members incur by seeing an out-of-network doctor. These superior methods include (a) contacting Coordinated Care to seek reimbursement, with an ultimate right to adjudication by an Independent Review Organization; (b) contacting the Office of the Insurance Commissioner for assistance; and (c)

participating in a remediation program ordered and approved by the Insurance Commissioner to address these costs. Plaintiff herself has successfully used two of these methods. These methods are effective—so much so that it is unlikely any significant number of members have unaddressed costs. Because expanding this case into a class action is not a superior way to address out-of-network costs as compared to existing and effective methods, this case fails Rule 23's superiority requirement.

Second, each time a member requests reimbursement for out-of-network costs, a ***highly individualized inquiry*** is required to address the request. Individualized issues predominate over any common issues, making these reimbursement requests impossible to address on a class-wide basis. If a class were certified, this Court would be required to delve into the unique facts of each individual request to address each request pursuant to the terms of the insurance policy. Moreover, as Plaintiff concedes, the issue of any damages is highly individualized. Because unique facts predominate each individual request, this case fails Rule 23's predominance requirement.

When a member incurs cost from an out-of-network provider, the member is able to utilize existing and effective methods to address that cost. These methods are approved by the Office of the Insurance Commissioner. They make more

sense than litigating individual requests as a class action, and they avoid injecting more inefficiencies and litigation into the health care system. If Plaintiff still has unaddressed costs from out-of-network care, Coordinated Care would like to address those costs.

BACKGROUND

A. Network adequacy

Washington requires that health insurers maintain an adequate network of healthcare providers. Specifically, the Office of the Insurance Commissioner ("OIC") requires that 80% of an insurer's members be within certain distances of in-network primary care providers and providers with various specialties, or the insurer must file an Alternative Access Delivery Request with the Insurance Commissioner to describe its plan to cover its members and reach in-network adequacy. *See* WAC 284-170-200(13)(b)(ii), (15); WAC 284-170-210; and Wendt Decl. ¶ 4. It is common (and permitted) in the health insurance industry to have networks that do not cover all members in all areas for all specialties. This happens for many reasons, including: (i) shortages of doctors in rural areas or specialized fields; and (ii) doctors or other providers choosing to stay out of network in order to negotiate higher fees. *See* Wendt Decl. ¶ 5.

B. The relevant insurance policy provision

The insurance policy at issue contemplates that a nearby in-network provider will not always be available, and it directs members to contact Coordinated Care in those circumstances. Wendt Decl., Ex. 1 at 12, 59, 71 (insurance policy). The policy states that Coordinated Care will cover costs incurred by members who see an out-of-network provider because no in-network provider is available. *See id*. at 59. This occurs from time to time, and Coordinated Care works to reimburse these costs in response to requests from members, contact from the OIC, or a response from a member to the remediation letters described below. *See* Wendt Decl. ¶ 8.

C. The OIC's consent order and remediation plan

In response to complaints similar to those raised by Plaintiff, the Office of the Insurance Commissioner conducted an investigation of Coordinated Care in 2017 and identified areas of inadequate in-network coverage, predominantly focused on anesthesiologists and emergency room providers in certain counties. In December 2017, the OIC entered into a consent order and remediation plan with Coordinated Care. *See* Wendt Decl., Ex. 2.

The OIC required Coordinated Care to (i) expand its network for certain types of providers in certain areas, and (ii) proactively contact its members to make them whole for costs they incurred by seeing an out-of-network provider when no

in-network provider was available. Wendt Decl., Ex. 2 at 1 & 4; Wendt Decl. ¶ 9. The OIC further required Coordinated Care to hire an external auditor, who reported to OIC, to oversee implementation of the remediation plan. Wendt Decl., Ex. 2 at 1.

Pursuant to the remediation plan, in April 2018 Coordinated Care sent letters to more than 73,000 of its members, including everyone who was a member in 2016 and 2017. The letter offered to resolve out-of-network costs that members incurred when no in-network provider was available. Wendt Decl. ¶ 11–13. The letter addressed two types of out-of-network costs: (1) where a member visits an out-of-network provider because no in-network provider was available, and (2) where a member visits an in-network facility but was billed for treatment by an out-of-network provider at the facility. *See* Wendt Decl. ¶ 12. The remediation letter was approved by the OIC, and it directed members to contact either Coordinated Care or the OIC to seek reimbursement. *See* Wendt Decl., Ex. 3 (remediation letter).

In addition, the external auditor overseeing the remediation plan sent a second remediation letter in June 2018 to more than 11,000 Coordinated Care members. The auditor selected those 11,000 Coordinated Care members for a follow-up letter based on their claims history. The auditor's letter similarly sought

to resolve out-of-network cost issues. *See* Wendt Decl., Ex. 4 (auditor letter); Wendt Decl. ¶ 15.

Several hundred members responded to the remediation letters—either directly to Coordinated Care, to the OIC, or to the auditor—and Coordinated Care addressed each of these responses under the oversight of the OIC and the external auditor. Wendt Decl. ¶ 16.

The OIC informed Coordinated Care in January 2019 that Coordinated Care had successfully completed the steps required by the remediation plan. Wendt Decl., Ex. 5 (letter from OIC). Pursuant to the insurance policy, Coordinated Care continues to resolve costs that members incur by seeing an out-of-network provider when no in-network provider is available, including when contacted by a member, contacted by the OIC, or when a member responds to the remediation letters. Wendt Decl. ¶ 19.[1]

[1] On January 1, 2020, new legislation went into effect that prohibits out-of-network providers from billing patients who seek treatment from in-network hospitals. This legislation reduces the likelihood that certain of the out-of-network costs complained about by Plaintiff will occur in the future. Wendt Decl. ¶ 21–23; *see also* WAC 284-43B-010.

D. Specific allegations

Plaintiff alleges that she incurred costs for out-of-network care because no in-network providers were available. Third Amended Complaint (TAC) ¶¶ 54, 54. She admits that Coordinated Care resolved many of these costs when she contacted Coordinated Care or the OIC, but she alleges that some remain unresolved. TAC ¶ 56; Mot. 1–2. Coordinated Care is unaware of any unresolved out-of-network costs incurred by Plaintiff. Wendt Decl. ¶ 27. Plaintiff points to Exhibit 54 of her motion to suggest that she has unresolved out-of-network costs, Mot. at 16–17, but the out-of-network costs identified in Exhibit 54 have been resolved consistent with the terms of her insurance policy and the consent order entered into between the Office of the Insurance Commissioner and Coordinated Care. Wendt Decl. ¶ 28.

Plaintiff's motion suggests that Coordinated Care did not cover kidney dialysis for its members because it had no dialysis centers in its network. Mot. at 9. That is not accurate. Before Coordinated Care had dialysis centers in its network, Coordinated Care covered dialysis treatment for its members by entering into a "Single Case Agreement" with a dialysis provider for each member who needed dialysis treatment, or it would simply pay the dialysis center directly for the treatment. Wendt Decl. ¶ 25. Either way, Coordinated Care would cover the

treatment and the member would not have out-of-network costs. *Id.* To Coordinated Care's knowledge, no member has outstanding out-of-pocket costs associated with receiving out-of-network dialysis treatment. *Id.* ¶ 26.

LEGAL STANDARD

Plaintiff bears the burden of demonstrating that this case meets the requirements of Federal Rule of Civil Procedure 23 and should be expanded into a class action. *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011). "Rule 23 does not set forth a mere pleading standard." *Id.* "A party seeking class certification must . . . be prepared to prove" that the Rule's requirements are "*in fact*" met. *Id.* For its part, "[b]efore certifying a class, the trial court must conduct a 'rigorous analysis' to determine whether the party seeking certification has met the prerequisites of Rule 23." *Mazza v. Am. Honda Motor Co.*, 666 F.3d 581, 588 (9th Cir. 2012) (quoting *Zinser v. Accufix Research Inst.*, 253 F.3d 1180, 1186 (9th Cir. 2001)). Plaintiff fails to clear this high bar because two essential elements of Rule 23 are not met: superiority and predominance.

THIS CASE SHOULD NOT BE EXPANDED INTO A CLASS ACTION

I. No Superiority: A Class Action Is Not Superior to Existing, Effective Methods of Recouping Out-of-Network Costs.

Rule 23(b)(3) permits certification only where "a class action is superior to other available methods for fairly and efficiently adjudicating the controversy." Fed. R. Civ. P. 23(b)(3). The superiority requirement serves to weed out cases unless they "can be adjudicated most profitably on a representative basis." *Zinser*, 253 F.3d at 1190. To that end, a court must consider "what other procedures, if any, exist for disposing of the dispute before it." 7AA Charles Alan Wright & Arthur R. Miller, Federal Practice and Procedure § 1779 (3d ed. 2008). The court "must compare the possible alternatives to determine whether [a class action] is sufficiently effective to justify the expenditure of the judicial time and energy that is necessary to adjudicate a class action." *Id.*

"A class action is the superior method for managing litigation *if no realistic alternative exists*." *Valentino v. Carter-Wallace, Inc.*, 97 F.3d 1227, 1234–35 (9th Cir. 1996) (emphasis added); *accord Rutledge v. Elec. Hose & Rubber Co.*, 511 F.2d 668, 673 (9th Cir. 1975) (noting that the superiority requirement demands that a class action be "superior to, *and not just as good as*, other available methods") (emphasis added).

The superiority analysis is not limited to comparing class actions to other forms of litigation such as individual lawsuits. The text of Rule 23(b)(3) refers broadly to "other available methods for fairly and efficiently adjudicating the controversy." Fed. R. Civ. P. 23(b)(3). The Rule's drafters recognized that "another method of handling the litigious situation may [have] greater practical advantages" than a class action. Fed. R. Civ. P. 23(b)(3) Advisory Committee Note. Accordingly, they chose language, including the expansive term "methods," that extends beyond judicial mechanisms. *See* Wright & Miller, *supra*, § 1779 ("The court need not confine itself to other available 'judicial' methods of handling the controversy in deciding the superiority of the class action.").

In this case, there are three effective alternative means for Coordinated Care members to recoup improperly incurred out-of-network costs. These methods are: (a) contacting Coordinated Care, (b) contacting the OIC, and (c) participating in the OIC-approved remediation plan that addresses the costs raised by Plaintiff.

A. A class action is not superior to contacting Coordinated Care.

The insurance policy at issue directs members to contact Coordinated Care if they have a problem, such as incurring costs from an out-of-network provider when no in-network provider is available. Wendt Decl., Ex. 1 at 74-75, 82 (insurance policy). The procedure in the insurance policy is straightforward.

Members can call or write to Coordinated Care to seek reimbursement. *See id.* at 74–78. Coordinated Care will work to resolve the issue by analyzing the unique facts of each request. *Id.* at 74. If the member is not satisfied with Coordinated Care's resolution, the member can escalate the issue to be adjudicated by an outside Independent Review Organization certified by the OIC. *Id.* at 75–78. The outside IRO's decision is binding on Coordinated Care. *Id.* at 78. This process has worked many times, and it leads to relatively efficient resolutions of out-of-network costs in nearly every instance in which a member has used it. *See* Wendt Decl. ¶ 29. In fact, prior to filing suit, Plaintiff herself had already successfully used the process. *See* TAC ¶ 56.

A class action offers no advantage over this process, which is approved by the OIC and allows for escalation to an Independent Review Organization if requested by the member. Indeed, a class action is inferior to the existing process because "any claims paid through the class action procedures would be reduced by the costs of suit and attorneys' fees." *Pattillo v. Schlesinger*, 625 F.2d 262, 265 (9th Cir. 1980); *see also In re Hotel Tel. Charges*, 500 F.2d 86, 91 (9th Cir. 1974) ("Whenever the principal, if not the only, beneficiaries to the class action are to be the attorneys for the plaintiffs and not the individual class members, a costly and

time-consuming class action is hardly the superior method for resolving the dispute.").

B. A class action is not superior to contacting the OIC.

A member can also contact the Office of the Insurance Commissioner if the member incurs costs from seeing an out-of-network provider when no in-network provider is available. When a member contacts the OIC, it will work to get the member's costs recouped, where appropriate. *See What we can (and can't do)*, https://www.insurance.wa.gov/what-we-can-and-cant-do (last visited Feb. 19, 2020). In 2019, the OIC processed over 6,000 requests from consumers and recovered almost $14 million. *Contacting us gets results*, https://www.insurance.wa.gov/contacting-us-gets-results (last visited Feb. 19, 2020).

Courts routinely find that processes like the OIC's are superior to class actions. The Ninth Circuit has long held that "administrative methods of settling the dispute" are relevant to determining whether "the class action is the most efficient and effective means of settling the controversy." *Kamm v. Cal. City Dev., Co.*, 509 F.2d 205, 211 (9th Cir. 1975). For example, in *Rowden v. Pac. Parking Sys.*, plaintiffs sued the city of Laguna Beach for printing parking receipts that displayed the expiration date of the driver's credit card in violation of federal law.

282 F.R.D. 581 (C.D. Cal. 2012). The court recognized that California law allows consumers to file administrative claims against the municipality and requires the public entity to investigate and settle claims "without the expense of litigation." *Id.* at 586 (internal quotation marks omitted). When compared to this "administrative claims process capable of expeditiously processing [Plaintiff's] claims," the court found that a class action could not be the superior method. *Id.* at 587.

Similarly, the Eastern District of California rejected a class action that sought to litigate an alleged motorcycle defect on a class basis. The court held that a class action was not superior to the National Highway Traffic Safety Administration's program that could investigate the defect and order the manufacturer to recall the vehicles for repair. *Johnson v. Harley-Davidson Motor Co.*, 285 F.R.D. 573, 584 (E.D. Cal. 2012). The court determined that it could provide no better relief by certifying a class. *Id. See also Chin v. Chrysler Corp.*, 182 F.R.D. 448, 464-65 (D.N.J. 1998) (finding that the administrative remedy is better than a class action); *In re Ford Motor Co. Ignition Switch Prods. Liab. Litig.*, 174 F.R.D. 332, 353 (D.N.J. 1997) (same).

The same logic applies here. The OIC's process is intended to help insureds with precisely the concerns at hand. The regulator's role saves the member time

and legal fees, and it focuses on the unique facts of each individual request for reimbursement.[2] Those advantages were presumably clear to Plaintiff, who successfully used the administrative process before pursuing litigation.[3] TAC ¶ 56.

C. A class action is not superior to the remediation plan ordered by the OIC.

In addition to contacting Coordinated Care or the OIC, a member also can participate in the OIC-ordered remediation plan described above. That plan includes a process for members to be reimbursed for costs that they incurred from an out-of-network provider because no in-network provider was available (i.e., "balance billing") or when a member received care from an out-of-network provider at an in-network facility (i.e., "surprise billing"). At the OIC's direction, Coordinated Care sent letters to more than 73,000 of its members inviting participation in the remediation plan. Wendt Decl. ¶ 11 & Ex. 3 to Wendt Decl.

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[2] The many unique and often personal facts particular to each request also create significant "difficulties in managing a class action," one of the key factors weighing against superiority. Fed. R. Civ. P. 23(b)(3); *see Grundmeyer v. Allstate Prop. & Cas. Ins.*, 2015 WL 9487928, at *3 (W.D. Wash. Sept. 29, 2015).

[3] An insured can simultaneously work with an insurance company and the OIC to seek reimbursement for out-of-network costs. *How to appeal a health insurance denial*, Washington OIC, https://www.insurance.wa.gov/how-appeal-health-insurance-denial (last visited Feb. 19, 2020).

The external auditor sent a follow-up letter to more than 11,000 of Coordinated Care's members. Wendt Decl. ¶ 15 & Ex. 4 to Wendt Decl. Coordinated Care's members responded to the remediation letters, and Coordinated Care issued reimbursements where appropriate.[4] Coordinated Care paid its members interest—at 8%—in connection with the reimbursement of these costs. Wendt. Decl., Ex. 2 at 4. This process was approved and overseen by the external auditor, in coordination with the OIC. Wendt Decl. ¶¶ 14, 16, 18. Coordinated Care will continue to address any further responses that it receives to these letters. *Id.* ¶ 19.

In instances where a remedy like this already is in place, courts routinely find that a subsequent class action fails to meet the superiority requirement. Courts have been especially reluctant to duplicate an agency's efforts. In a seminal case on administrative remedies in the context of superiority, *Kamm v. California City Development Co.*, the Ninth Circuit considered a putative class action brought against real estate companies for a fraudulent land-promotion scheme. 509 F.2d

[4] Although Plaintiff complains that the remediation plan required affected members to "self-identify" (Mot. at 13), the remediation letter sent by Coordinated Care is very similar to the notice that would be given to class members should Plaintiff prevail on class certification. *See Imber-Gluck v. Google Inc.*, 2015 WL 1522076, at *3–4 (N.D. Cal. Apr. 3, 2015) ("[I]t is unlikely that a class notice and claims process achieved through this litigation would be much different than that under the FTC settlement.").

205. Before plaintiffs brought suit, the state's Attorney General and Real Estate Commissioner had sued the defendants. *Id.* at 207. The AG's action led to a settlement agreement that required defendants to pay restitution and establish a program to settle any remaining disputes. *Id.* at 208.

The court found that a class action was not superior to the AG's action and resulting remedies. It stressed several factors in the superiority analysis, including that: (1) "[a] class action would require a substantial expenditure of judicial time which would largely duplicate and possibly to some level negate the work on the state level"; (2) "[s]ignificant relief had been realized in the state action" through the settlement agreement and restitution payments; (3) the class action would include numerous members involved in separate transactions over a long period; and (4) the class action would be costly and duplicate work expended in the state action. *Id.* at 212. At bottom, the court rejected the class action because the AG action and a class action "involve the same fraudulent conduct of the defendants and both seek to provide relief for those injured thereby." *Id.* at 213.

The court's reasoning in *Kamm* compels the same result here. All the factors weigh against a finding of superiority. In comparing the existing remedies and a class action, this case is even more clear-cut than *Kamm*: both methods would address the same issues, involve the same members and insurer, and provide

the same relief. *See Murray v. DirecTV, Inc.*, 2014 WL 12597904, at *3–4 (C.D. Cal. Apr. 23, 2014) (finding lack of superiority where both the administrative remedy and the class action lawsuit target the same statutory violation and provide relief to the same consumers). It makes little sense for this Court to retread the exact same ground that the OIC and Coordinated Care have previously covered. *See, e.g.*, *Conde v. Sensa*, 2018 WL 4297056, at *14–16 (S.D. Cal. Sept. 10, 2018) (applying *Kamm* to deny class certification based on prior FTC settlement that covers the same issues and relief as the putative class action); *Imber-Gluck*, 2015 WL 1522076, at *3–4 (reaching the same conclusion and noting that the "FTC investigation was based on the same underlying conduct as the instant litigation, [and] the FTC settlement provides complete refunds to the class members").

A class action is particularly inappropriate in a case like this where there is an existing reimbursement program. *See, e.g.*, *In re Phenylpropanolamine (PPA) Prods. Liab. Litig.*, 214 F.R.D. 614, 622–23 (W.D. Wash. 2003) (finding that, in light of defendants' refund and product replacement programs, the class mechanism was "unnecessary to afford the class members redress"); *Webb v. Carter's Inc.*, 272 F.R.D. 489, 505 (C.D. Cal. 2011) (concluding that "a class action is not superior because [defendant] is already offering the very relief that Plaintiffs seek"). Here, Coordinated Care and the OIC give members a low-cost,

simple way to secure reimbursement for out-of-network costs where appropriate, with interest. There is no chance that a class action would be more efficient or less costly. *See Pattillo*, 625 F.2d at 265 (finding that "a class action procedure is not superior to the ongoing administrative proceedings for the notification and payment" of members of the proposed class).

This is an unusual case where three overlapping mechanisms exist to address the out-of-network costs that Plaintiff asks this court to adjudicate. The usual rationale for class actions—that plaintiffs lack resources or sufficient incentive to pursue individual claims—does not apply here, where Coordinated Care's members have multiple low-cost methods to receive reimbursement and an Insurance Commissioner to advocate (and regulate) for their interests. Because a class action is not superior to these alternative methods, class certification should be denied.

II. No Predominance: Common Issues Do Not Predominate over Highly Individual Issues Regarding Reimbursement for Out-of-Network Costs.

Rule 23(b)(3) permits certification only where a plaintiff can show "that the questions of law or fact common to class members predominate over any questions affecting only individual members." Fed. R. Civ. P. 23(b)(3). Courts must give "careful scrutiny to the relation between common and individual questions," and

may not certify a class unless the "common, aggregation-enabling, issues in the case are more prevalent or important than the non-common, aggregation-defeating, individual issues." *Tyson Foods v. Bouaphakeo*, 136 S. Ct. 1036, 1045 (2016) (citation omitted). This test is "far more demanding" than Rule 23(a)(2)'s commonality requirement, *Amchem Prods. v. Windsor*, 521 U.S. 591, 624 (1997), which itself is not satisfied by just *any* common question, but only by a question the resolution of which "will resolve an issue that is central to the validity of each one of the claims in one stroke." *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 350 (2011). A single individualized element can defeat predominance: for example, if there is no method of measuring damages on a classwide basis, "[q]uestions of individual damage calculations will inevitably overwhelm questions common to the class." *Comcast Corp. v. Behrend*, 569 U.S. 27, 34 (2013).

Plaintiff asserts two causes of action: unfair practices in violation of the Washington Consumer Protection Act ("CPA") and breach of contract. These causes of action are the vehicle for her two theories of liability: that Coordinated Care (1) maintained an inadequate provider network and (2) misrepresented the scope of its provider network by maintaining an inaccurate provider directory,

thereby causing some class members to incur out-of-network costs.[5] *See* Mot. 25, 28, 29–31.

Plaintiff proposes a class of every person who purchased an Ambetter insurance policy from Coordinated Care in Washington. Unsurprisingly, Plaintiff offers no model for adjudicating the unique facts of each request for out-of-network costs on a class-wide basis. If the Court were to certify the class that Plaintiff proposes, it would have to hold a mini-trial for every class member to determine whether the member was charged an out-of-network cost, the reason that care was sought from an out-of-network provider, the availability of an in-network provider at the relevant time and for the relevant specialty, whether the member paid some or all of the out-of-network cost, the amount of any applicable deductible, whether Coordinated Care already remediated the cost, and the appropriate reimbursement amount. This work would be necessary to address each unique request because in some circumstances, the member is entitled to reimbursement; in others, the member is not. For this reason, Rule 23(b)(3)'s predominance requirement is not satisfied.

[5] Plaintiff's class certification motion cites various statutory and regulatory provisions, *e.g.*, Mot. 20, 25–26, but all are tied to those two fundamental theories.

A. The question of injury is individualized.

To prevail on a claim under the Consumer Protection Act or for breach of contract, a class member must prove actual injury. A CPA injury "need not be great, but it must be established." *Hangman Ridge Training Stables v. Safeco Title Ins. Co.*, 719 P.2d 531, 539–40 (Wash. 1986) (en banc). Similarly, a breach-of-contract claim requires a showing of actual damages. *DC Farms, LLC v. Conagra Foods Lamb Weston, Inc.*, 317 P.3d 543, 553 (Wash. Ct. App. 2014).

Plaintiff advances a single theory of injury: that some class members incurred out-of-network costs because they saw out-of-network providers whose services Coordinated Care (allegedly) should have covered. *See* Mot. 28. Her three categories of CPA injury—"(1) improper claims denials, (2) overcharges at out-of-network rates and/or (3) improper balance billing," Mot. 28—are all just different phrasings of this same theory, which underlies the breach-of-contract claim as well. *See* Mot. 30. Every class member, then, will face the individual question whether they actually incurred and paid "improper charges" for out-of-network care. *Id.*

The proposed class definition, covering everyone who purchased an Ambetter policy from Coordinated Care since 2012, makes no attempt to limit class membership to those who were actually injured. *See* Schexnaydre Decl.

¶¶ 19, 47 (acknowledging that of 99,439 members, only 14,117 "may have" received a balance bill). Plaintiff recognizes the possibility that "some class members did not incur improper charges," Mot. 28, but waves this barrier away, arguing that "all class members were subjected and exposed to the same unlawful conduct." Mot. 28. But courts routinely recognize that the presence of uninjured class members will require the court to determine the individualized fact of injury among the group, and thus Rule 23's predominance standards are not met. *See, e.g.*, *Lucas v. Breg, Inc.*, 212 F. Supp. 3d 950, 970 (S.D. Cal. 2016) (recognizing that "a proposed class action requiring the court to determine the individualized *fact* of damages does not meet the predominance standards of Rule 23(b)(3)" (citation omitted)).

Plaintiff relies on *Torres v. Mercer Canyons Inc.*, 835 F.3d 1125 (9th Cir. 2016), for the proposition that "even a well-defined class may inevitably contain some individuals who have suffered no harm as a result of a defendant's unlawful conduct." *Id.* at 1136. But in *Torres*, the Ninth Circuit was addressing a broader argument—that a class with uninjured members can never be certified. *See id.* The court did not hold that individualized questions of injury may never defeat predominance on the facts of a particular case. *See id.* at 1136-37. Indeed, courts since *Torres* have found predominance lacking where individual questions of

injury would overwhelm common questions regarding defendants' alleged conduct. *See, e.g.*, *Andrews v. Plains All Am. Pipeline, L.P.*, 777 F. App'x 889, 892 (9th Cir. 2019) (distinguishing *Torres* as a case where "exposure to the alleged misconduct was itself the injury" and holding predominance was defeated where plaintiff's data showed many class members "likely were not injured"); *Lucas*, 212 F. Supp. 3d at 970.

Torres also recognized that "class membership must fit the theory of legal liability," meaning the plaintiff's theory of injury must "actually map[] onto the membership of the class." 835 F.3d at 1138. Plaintiff's theory of injury in the present case requires a showing of improper out-of-network costs, while her class definition sweeps in *everyone* who bought an Ambetter policy from Coordinated Care. This poor fit between injury and class definition distinguishes this case from *Torres*.

Determining whether any member of the proposed class has actually been injured would involve a complex, fact-intensive, individualized inquiry. The factfinder would need to determine whether each class member actually was treated by an out-of-network provider; whether that was because no in-network provider was available; whether the member received a bill from the out-of-network provider; whether the member paid the bill or the provider wrote off the

cost; and whether the member resolved the issue through Coordinated Care or the OIC, *see supra* Section I. Even if the member paid a cost for out-of-network care because an in-network provider was unavailable, the jury would have to determine what the member would have paid had they gone to an in-network provider, including co-payments and deductibles, to determine whether there was actual injury, and if so, the amount.[6] Coordinated Care does this work each time a member requests reimbursement of out-of-network costs; it would be burdensome and inefficient for this Court to take on that task.

Because there are many reasons why a member may see an out-of-network provider, the mere fact that a member went to an out-of-network provider does not mean that the particular member incurred improper costs. For this reason, the insurance policy encourages members to contact Coordinated Care if they are having difficulty finding an in-network provider so the issue can be addressed before care is received, and it provides a simple procedure for members to recoup

[6] The Ambetter insurance policies have a deductible. *See* Wendt Decl., Ex. 1 at 5, 11 (insurance policy). Except for certain preventative care, a member must pay for care (whether in-network or out-of-network) until the deductible is met. For many members, the deductible may mean that the member incurred no additional out-of-pocket costs from seeing an out-of-network provider vis-à-vis an in-network provider.

out-of-network costs that they believe are improper. *See* Wendt Decl., Ex. 1 at 12, 58 (insurance policy).

In sum, proof that a member incurred costs from an out-of-network doctor is necessary, but not sufficient, to show that the costs were inappropriate and thus the member was injured. And Plaintiff's data analysis does not even reach the first step of identifying members who incurred out-of-network charges from those who did not. Individual issues predominate in this case because determining liability and damages for each member would require a "review of each class member's medical, billing, and insurance records to determine whether each suffered an out-of-pocket loss." *Lucas*, 212 F. Supp. 3d at 970.

B. The question of causation is individualized.

Both a CPA claim and a breach-of-contract claim require the plaintiff to show not only that they suffered an injury, but also that the defendant's conduct proximately caused the injury. *Indoor Billboard/Wash., Inc. v. Integra Telecom of Wash., Inc.*, 170 P.3d 10, 22 (Wash. 2007) (en banc) (CPA claim); *Nw. Indep. Forest Mfrs. v. Dep't of Labor & Indus.*, 899 P.2d 6, 9 (Wash. Ct. App. 1995) (breach of contract claim).

Causation is an individualized issue in this case. Whether Plaintiff's argument is that (1) Coordinated Care violated the CPA or breached its contracts

with members by providing inadequate access to covered providers in certain locations or for certain specialties, or (2) that Coordinated Care misrepresented its provider network through an inaccurate directory, each class member would need to individually show that a network problem or misstatement caused them to seek out-of-network care.[7] Those questions would require a mini-trial for every class member and so defeat predominance.

1. Establishing a causal link between network issues and class member's injury requires individualized showings.

Plaintiff asserts that Coordinated Care caused members to incur out-of-network costs by "failing to maintain an adequate provider network" in violation of the CPA and its contracts. Mot. 25, 29. Every class member, then, must prove that

[7] Plaintiff's motion also suggests a third theory of liability: that Coordinated Care violated the CPA by "fail[ing] to disclose that members are not responsible for charges by out-of-network providers over the members' cost-sharing amount where there is a network inadequacy." Mot. 25. This theory does not appear in the Complaint, which relies only on the inadequate-network and inaccurate-directory theories. *See* TAC ¶¶ 42–49 (general allegations); *id.* ¶¶ 53–58 (allegations as to Plaintiff Harvey and putative class members). Plaintiff may not seek certification of a claim that is not in the Complaint. *In re First Am. Home Buyers Prot. Corp. Class Action Litig.*, 313 F.R.D. 578, 609 (S.D. Cal. 2016). Regardless, this theory would not satisfy the predominance requirement due to the same individualized questions of reliance, injury, and damages discussed for Plaintiff's existing theories—and it is undermined by the language in the insurance policy. *See* Wendt Decl., Ex. 1 at 12 (insurance policy).

but for a network inadequacy, they would have seen an in-network provider *and* paid less overall. *See Nguyen v. Nissan N. Am., Inc.*, 932 F.3d 811, 817 (9th Cir. 2019) (recognizing that under *Comcast*, plaintiffs must link liability and damages to secure class certification).

That is an individualized inquiry. Even assuming that Plaintiff can prove specific areas where certain specialties were not available in network, that showing would not complete the chain of causation. A patient may see an out-of-network provider for any number of reasons apart from an insufficient number of in-network providers within a reasonable distance. For example, they may prefer to see a certain doctor; they may have difficulty scheduling an appointment with an in-network doctor, despite the adequacy of the network; a doctor may choose to leave Coordinated Care's network; or the patient might just not check the provider's network status. Evaluating which of these and other possible reasons may have led a member to obtain out-of-network care requires an inquiry into the individual motivations and circumstances behind every visit to an out-of-network provider.

Courts in this Circuit have frequently denied class certification on the ground that individualized questions of causation would predominate over common questions. *See, e.g.*, *Poulos v. Caesars World, Inc.*, 379 F.3d 654, 665

(9th Cir. 2004) (individual questions regarding causal link between alleged misrepresentations and members' decision to gamble defeated predominance). This is particularly true in the insurance context, given that there are often legitimate reasons why a claim may be denied. *See, e.g.*, *O'Dell v. Conseco Senior Health Ins. Co.*, 2011 WL 13044240, at *7 (W.D. Wash. Feb. 10, 2011) (recognizing that determining the reason why insurance company paid benefits at a lower tier "would require a manual review of each claim file, resulting in mini-trials for each class member"); *Campion v. Old Republic Home Prot. Co.*, 272 F.R.D. 517, 531 (S.D. Cal. 2011) (observing that even a "uniform policy that encourages the wrongful denial of claims" would not establish classwide causation because some claims are denied legitimately). So too here. There is no way to prove, on a class-wide basis, which out-of-network costs incurred by Coordinated Care members were caused by a lack of an in-network alternative.

2. Establishing a causal link between alleged misstatements and class member's injury requires individualized showings.

Plaintiff contends that Coordinated Care violated the CPA by "misrepresenting its actual provider network to consumers" in its directory of providers and its marketing materials. Mot. 25. Plaintiff's theory would require

each class member to show that Coordinated Care's alleged misrepresentations were the but-for cause of their decision to seek out-of-network care. *Indoor Billboard/Wash., Inc.*, 170 P.3d at 22. This "fact-intensive, individual inquiry into the motivations of each consumer," *Kelley v. Microsoft Corp.*, 2011 WL 13353905, at *3 (W.D. Wash. May 24, 2011), differs little in substance from a traditional reliance analysis.

Courts routinely deny class certification in cases where the plaintiff's claim requires a showing of reliance. *See, e.g.*, *Mazza*, 666 F.3d at 596 (denying class certification where some class members were never exposed to misleading statements, and others learned allegedly omitted information before making purchase); *Geier v. M-Qube Inc.*, 314 F.R.D. 692, 700–01 (W.D. Wash. 2016) (denying class certification on Washington CPA claim); *O'Dell*, 2011 WL 13044240, at *8 (same).

Plaintiff tries to avoid this problem by suggesting that her misrepresentation claim is "based on omissions." Mot. at 29. Not so. Plaintiff's deception theory, as pleaded in the Complaint, rests on alleged affirmative misrepresentations. Specifically, Plaintiff alleges that Coordinated Care misstated the scope of its network and the benefits of its Ambetter plans, TAC ¶¶ 42–46, and included providers in its directory who did not actually belong in its network, *id.* ¶ 47.

Coordinated Care allegedly "omitted" only that its affirmative statements were false.[8] Such "mirror image" omissions claims do not pass muster. *See Blough v. Shea Homes, Inc.*, 2014 WL 3694231, at *13 (W.D. Wash. July 23, 2014). The Court should reach the same conclusion here.

C. The question of damages is individualized.

Plaintiff concedes that the amount of each class member's damages—separate from the question whether the class member suffered an injury—is an individualized question. Mot. 30–31. She argues, though, that this does not matter, because individualized damages questions cannot defeat predominance. *Id.* Plaintiff overlooks a crucial nuance. Individual damages assessments do not defeat predominance *if* "a valid method has been proposed for calculating those damages." *Nguyen*, 932 F.3d at 817 (quoting *Lambert v. Nutraceutical Corp.*, 870 F.3d 1170, 1182 (9th Cir. 2017)). A class plaintiff must do more than propose an arbitrary methodology; she must demonstrate that her methodology actually links

[8] If Plaintiff instead contends the relevant omission is Coordinated Care's "failure to disclose that it was required under Washington law to protect insureds from improper balance billing when its network was inadequate," Mot. at 29, the Court should reject that theory on the grounds that it is not within the Complaint. *Supra* note 7.

the defendant's alleged misconduct and class members' damages. *See Comcast*, 569 U.S. at 35–36.

Plaintiff has done no such thing. Her data analysis does not even claim to calculate the out-of-network costs that class members incurred because an in-network provider was not available, or even to identify which class members faced an inadequate network of the particular type of provider that they needed at the time and in their area. She thus offers no formula to calculate damages on a class-wide basis as did the plaintiffs in *Nguyen*, 932 F.3d at 821, who sought damages based on the average cost of repair for a defective part, or in *Pulaski & Middleman, LLC v. Google, Inc.*, 802 F.3d 979, 989 (9th Cir. 2015), who sought damages based on a straightforward discount ratio that the defendant already employed internally.

Here, no such formula or methodology exists because calculating each class member's damages if any would involve an exhaustive case-by-case review. *See Daniel F. v. Blue Shield of Calif.*, 305 F.R.D. 115, 131 (N.D. Cal. 2014) (rejecting plaintiff's proposal of an "essentially mechanical process" for calculating damages sustained by health insurance policyholders where "calculating damages would require manual review of each claimant's records, as well as discovery on what each claimant actually paid, what he/she still owes, [and] the nature of the services provided"); *see also Flores v. Supervalu, Inc.*, 509 F. App'x 593, 594 (9th Cir.

2013) (denying class certification when questions of individualized behavior meant plaintiff "could not prove the employer's liability through extrapolation from statistics"). The individualized nature of damages here is yet another badge of a lack of predominance. Plaintiff has "made no attempt to explain how the court could possibly try this case as a class action given the number of individual issues involved." *Blue Shield*, 305 F.R.D. at 132.

* * *

This case is unworkable as a class action. For each request for reimbursement of out-of-network costs, a detailed analysis of unique facts is required. The factfinder must examine the reason that care was sought from an out-of-network provider, the availability of an in-network provider in the relevant location and at the relevant time, the amount of any applicable deductible, and more. This work often involves sensitive medical issues and is necessary because in some circumstances, the member is entitled to reimbursement; in others, the member is not. As a result, each request would require a mini-trial, and certifying a class action would be counterproductive and unwieldy. Moreover, class members surely would receive less after legal fees than they would receive by using one of the currently available methods of seeking reimbursement for out-of-

network costs, all of which are approved by the Office of the Insurance Commissioner.

CONCLUSION

For the foregoing reasons, the Court should deny Plaintiffs' Motion for Class Certification.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on February 19, 2020, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF System, which in turn automatically sent a Notice of Electronic Filing to all parties in the case who are registered users of the CM/ECF system. The Notice of Electronic Filing for the foregoing specifically identifies recipients of electronic notice.

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